CCPU HEALTH CARE FUND

Health Care Fund Application

Fields indicated with (*) are required.

YOUR INFORMATION

*First Name	Middle Name	*Last Name	Suffix (i.e., Jr, Sr, I, II, III)

*Email	*Mobile Number	*Birth Date (mm/dd/yyyy)	*Social Security / ITIN
			☐ I don't have one

*Mailing Address

*City	*State	*Postal Code

Home Address *(if different than mailing address above)*

City	State	Postal Code

*Preferred Language

☐ English ☐ Spanish ☐ Arabic ☐ Chinese (Simplified)
☐ Chinese (Traditional) ☐ Other _____

*What type of provider are you?

☐ Licensed: License Number _____
☐ Family, Friends, and Neighbors / License Exempt ☐ Not sure

Business Name

*Gender

☐ Male ☐ Female

Ethnicity

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Do not want to specify

Are you a member of Child Care Providers United?	How many subsidized children do you work with?	*Preferred Method of Communication (select one)
☐ Yes ☐ No ☐ Not Sure	☐ 1-3 ☐ 3-5 ☐ 5+	☐ Mail ☐ E-Mail

YOUR HEALTH PLAN

*(Check One) Please select your *current* Health Insurance. Note: If you select Employer Plan, you'll need to identify if you're the employee or dependent.

☐ Covered California – Plan Name: _____

☐ Employer Plan
If selected: ☐ Employer Plan as Employee ☐ Employer Plan as Dependent ☐ Veterans/Tricare Plan

☐ Medi-Cal	☐ Medicare	☐ Medicare Advantage	☐ Both Medi-Cal and Medicare (Medi-Medi-Plan)

☐ I do not have a qualified health plan and need assistance with enrollment

If selected: Household Size _____ Household Income _____

SIGN AND ACKNOWLEDGE

I, the undersigned, understand and agree that:

- The CCPU Health Care Fund is not health insurance.
- I must select and maintain coverage in a qualifying health insurance plan that has been approved by the Board of Trustees to receive any CCPU Health Care Fund benefits.
- My spouse, domestic partner, and dependents are not eligible for any CCPU Health Care Fund benefit.
- I have to pay my own premiums for qualifying health plan insurance coverage.
- I must timely respond to all notices and requests for information from the CCPU Health Care Fund and its affiliates, failure to do so may delay or interrupt my benefits through this program.
- We will keep you informed about your submitted application through your preferred method of communication, either by email or mail. Please note, this does not apply to communications for reimbursement requests – it is mandatory to send these types of communications electronically.

I attest that the information in this application is true and accurate. I understand that if I provide incomplete, false or misleading information, my application may be denied, my participation in the CCPU Health Care Fund may be terminated, and my claims may be denied. I will inform the CCPU Health Care Fund about any changes to the information in this application within 30 days of the change. I also understand that submitting this application does not guarantee my benefits or enroll me in a health benefit plan or health insurance coverage through Covered California or any other insurance carrier. I agree to indemnify and hold the CCPU Health Care Fund and the Board of Trustees harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

*Signature	*Date (mm/dd/yyyy)

TO SUBMIT PLEASE EMAIL, FAX OR MAIL THIS COMPLETED APPLICATION WITH PROOF OF COVERAGE (SEE BACK) TO:

apply@ccpuhealth.org | Fax: (949) 809-8920 | Child Care Providers United – California Workers Health Care Fund, P.O. Box 57027, Irvine, CA 92619
Additional Help: (833) 714-6028 | support@ccpuhealth.org

APPLY ONLINE FOR FASTER PROCESSING, PLEASE VISIT
WWW.CCPUHEALTH.ORG

CCPU HEALTH CARE FUND

Health Care Fund Application

SUBMITTING YOUR PROOF OF COVERAGE

To complete your CCPU Health Care Fund Application, we require *proof of coverage* of your current medical health insurance plan. This supplementary documentation should provide details that verify your name as the policy holder, your health care plan name, and the coverage period.

Some examples of qualified health plan names include:

- Anthem Silver 70 HMO
- Kaiser Permanente Silver 70 HMO
- CCHP Silver 70 HMO
- Western Health Advantage Silver 70 HMO

We've included a list of documents we can accept as proof of coverage, depending on your current health insurance plan.

If you selected Covered California on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Premium billing statement with effective date and premium (if applicable), and any APTC is applicable
- ☐ Certificate of coverage with effective date and premium (if applicable)
- ☐ Explanation of benefits

If you selected Medi-Cal on page 1, please submit of one these document options (with effective date and premium amounts listed):

- ☐ Copy of Healthcare ID card **and** a copy of your 1095
- ☐ Re-Determination of Benefits letter
- ☐ Verification of Benefits (from your local county office)

If you selected Medicare on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Premium billing statement (Part A&B and/or D) and Medicare card
- ☐ Certificate of coverage
- ☐ Medicare eligibility letter

If you selected Medicare Advantage on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Premium billing statement (Part C and/or D) and Medicare card
- ☐ Certificate of coverage

If you selected Both Medi-Cal and Medicare (Medi-Medi) on page 1, please submit one document from each of the following sections (with effective date and premium amounts listed):

For Medicare:

- ☐ Premium Billing Statement (Part A&B and/or D) and Medicare card
- ☐ Certificate of Coverage
- ☐ Medicare Eligibility Letter

For Medi-Cal:

- ☐ Copy of Medi-Cal ID Card(s) and a copy of your most recent 1095-A
- ☐ Verification of Benefits (from your local county office)
- ☐ Redetermination of Benefits Letter

If you selected Veterans/Tricare on page 1, please submit 1 of the following:

- ☐ Premium billing statement that provides the following: effective date and premium amount.
- ☐ Veterans/Tricare Eligibility letter with effective date of benefits and premium amount (if applicable)

If you selected Employer Plan (as Employee) on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Paycheck/payroll stub that clearly shows medical deduction amount and the cadence (bi-weekly, monthly)
- ☐ Certificate of coverage with effective date and premium (if applicable)

If you selected Employer Plan (as Dependent) on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Certificate of coverage with effective date and premium (if applicable)
- ☐ Open enrollment form with effective date and premium (if applicable)
- ☐ Benefits Summary with effective date and premium (if applicable)

If you selected Provider without an SSN/TIN) on page 1, please submit one of these documents (with effective date and premium amounts listed):

- ☐ Premium billing statement that provides the following: effective date and premium amount, and any Advanced Premium Tax Credit (if applicable).
- ☐ Certificate of coverage with monthly premium amount and effective date

APPLY ONLINE
FOR FASTER PROCESSING,
PLEASE VISIT
WWW.CCPUHEALTH.ORG